



**GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIDIABETIC AGENTS PA SUMMARY**

Preferred	Non-Preferred
<i>Dipeptidyl Peptidase-4 (DPP-4) Inhibitors</i>	
Januvia (sitagliptin) Janumet (sitagliptin/metformin) Jentadueto (linagliptin/metformin) Kombiglyze (saxagliptin/metformin) Onglyza (saxagliptin) Tradjenta (linagliptin)	Alogliptin 6.25mg, 12.5mg generic Alogliptin/metformin generic Alogliptin/pioglitazone Janumet XR (sitagliptin/metformin ER) Jentadueto XR (linagliptin/metformin ER) Nesina 25mg (alogliptin)
<i>Meglitinides</i>	
Nateglinide generic Repaglinide generic	Prandimet (repaglinide/metformin) Repaglinide/metformin generic
<i>Metformin Products</i>	
Metformin generic Metformin ER (generic Glucophage XR, Glumetza) Riomet (metformin IR oral solution)	Fortamet (metformin ER osmotic) Metformin ER osmotic (generic Fortamet ER) Riomet ER (metformin ER oral suspension)
<i>Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors</i>	
Farxiga (dapagliflozin) Invokamet (canagliflozin/metformin) Invokana (canagliflozin) Jardiance (empagliflozin) Xigduo XR (dapagliflozin/metformin ER)	Glyxambi (empagliflozin/linagliptin) Invokamet XR (canagliflozin/metformin ER) Qtern (dapagliflozin/saxagliptin) Segluromet (ertugliflozin/metformin) Steglatro (ertugliflozin) Steglujan (ertugliflozin/sitagliptin) Synjardy (empagliflozin/metformin) Synjardy XR (empagliflozin/metformin ER) Trijardy XR (empagliflozin/linagliptin/metformin ER)
<i>Sulfonylureas</i>	
Glimepiride generic Glipizide generic Glyburide generic	Chlorpropamide generic Tolazamide generic Tolbutamide generic
<i>Thiazolidinediones (TZD)</i>	
Pioglitazone generic	Actoplus Met XR (pioglitazone/metformin ER) Avandia (rosiglitazone) Avandamet (rosiglitazone/metformin)



	Pioglitazone/glimepiride generic Pioglitazone/metformin generic
Miscellaneous Antidiabetic Agents	
Bydureon (exenatide ER)* Byetta (exenatide)* SymlinPen (pramlintide)* Victoza (liraglutide)*	Adlyxin (lixisenatide) Bydureon BCise (exenatide ER) Cycloset (bromocriptine) Ozempic (semaglutide injection) Rybelsus (semaglutide tablets) Soliqua (insulin glargine/lixisenatide) Tanzeum (albiglutide) Trulicity (dulaglutide) Xultophy (insulin degludec/liraglutide)
Alpha-Glucosidase Inhibitors	
Acarbose generic Miglitol generic	

*Preferred agents that require PA; ER/XR=extended-release; IR=immediate-release

LENGTH OF AUTHORIZATION: Varies

NOTES:

- Bydureon, Byetta, SymlinPen and Victoza are preferred but require prior authorization (PA).
- If generic repaglinide/metformin is approved, the PA will be issued for brand Prandimet.

PA CRITERIA:

Alogliptin 6.25mg, 12.5mg Generic and Nesina 25mg

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose hemoglobin A1c (HbA1c) level is 7% or higher and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with Januvia, Onglyza and Tradjenta.

Alogliptin/Metformin Generic

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with Janumet, Jentadueto and Kombiglyze.

Alogliptin/Pioglitazone Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, generic pioglitazone and brand Nesina 25mg or generic alogliptin 6.25mg or 12.5mg as well as Januvia, Onglyza and Tradjenta, are not appropriate for the member.



Janumet XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, Januvia and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Jentadueto XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Tradjenta and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Prandimet and Repaglinide/Metformin Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, generic repaglinide and generic metformin, are not appropriate for the member.

Fortamet and Metformin ER Osmotic Generic

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, metformin ER (generic Glucophage XR and generic Glumetza), are not appropriate for the member.

Riomet ER Oral Suspension

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, Riomet IR Oral Solution, is not appropriate for the member.

Glyxambi

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have failed to achieve HbA1c goal with Janumet, Jentadueto or Kombiglyze.

Invokamet XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Invokamet as well as Invokana with generic metformin ER (generic Glucophage XR and generic Glumetza), are not appropriate for the member.

Otern

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate preferred products, Farxiga and generic Onglyza, are not appropriate for the member.

Segluromet

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Steglatro and generic metformin, are not appropriate for the member.

Steglatro

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with metformin,



thiazolidinedione or sulfonylurea, and at least one preferred SGLT2 inhibitor (Farxiga, Invokana or Jardiance).

Steglujan

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Steglatro and Januvia, are not appropriate for the member.

Synjardy

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jardiance and generic metformin, are not appropriate for the member.

Synjardy XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jardiance and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Trijardy XR

- ❖ Prescriber must submit a written letter of medical necessity stating the reasons the separate products, Jardiance, Tradjenta and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Chlorpropamide Generic, Tolazamide Generic and Tolbutamide Generic

- ❖ Approvable for members who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least 2 preferred sulfonylurea products.

Actoplus Met XR

- ❖ Physician must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone and metformin ER (generic Glucophage XR, Glumetza), are not appropriate for the member.

Avandia and Avandamet

- ❖ Approvable for members with a diagnosis of type 2 diabetes mellitus who have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with pioglitazone.

Pioglitazone/Glimepiride Generic

- ❖ Physician must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone and generic glimepiride, are not appropriate for the member.

Pioglitazone/Metformin Generic

- ❖ Physician must submit a written letter of medical necessity stating the reasons the separate preferred products, generic pioglitazone and generic metformin, are not appropriate for the member.



Adlyxin, Tanzeum and Trulicity

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with Byetta or Bydureon and Victoza.

Bydureon, Bydureon BCise, Byetta and Victoza

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, sulfonylurea and/or thiazolidinedione therapy.
- ❖ In addition for Victoza, approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus who have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease or peripheral artery disease).
- ❖ In addition for Bydureon BCise, prescriber must submit a written letter of medical necessity stating the reasons the preferred products, Bydureon as well as Byetta and Victoza, are not appropriate for the member.

Cycloset

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with metformin, sulfonylurea, thiazolidinedione and dipeptidyl-peptidase-4 inhibitor.

Ozempic

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with Byetta or Bydureon and Victoza.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus who have established cardiovascular disease (history of coronary artery disease, stroke, cerebrovascular disease or peripheral artery disease) who have experienced an inadequate response, allergy contraindication, drug-drug interaction or intolerable side effect with Victoza.

Rybelsus

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin, sulfonylurea and/or thiazolidinedione therapy and have failed to achieve HbA1c goal or have allergies, contraindications, drug-drug interactions or intolerable side effects with Farxiga, Jardiance or Invokana and Bydureon, Byetta or Victoza.

Soliqua

- ❖ Approvable for members who have been stabilized on combination therapy with the individual agents, Lantus and Adlyxin.



- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin and have failed to achieve glycemic targets with combination therapy of Lantus and Victoza as well as combination therapy of Lantus and Byetta or Bydureon, or have allergies, contraindications, drug-drug interactions or intolerable side effects to metformin, Byetta or Bydureon and Victoza.

SymlinPen

- ❖ Approvable for members 18 years of age or older with a diagnosis of type 1 or type 2 diabetes mellitus whose HbA1c level is 7% to 9% currently on insulin therapy.

Xultophy

- ❖ Approvable for members who have been stabilized on combination therapy with the individual agents, Tresiba and Victoza.
- ❖ Approvable for members 18 years of age or older with a diagnosis of type 2 diabetes mellitus whose HbA1c level is 7% or higher currently on metformin and have failed to achieve glycemic targets with combination therapy of Lantus and Victoza as well as combination therapy of Levemir and Victoza, or have allergies, contraindications, drug-drug interactions or intolerable side effects to metformin, Lantus and Levemir.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to <http://dch.georgia.gov/prior-authorization-process-and-criteria> and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL List.